| IPDR6702 RUN DATE: | 02/06/2006 | | IPR | NORTH CAROLINA S CHECKWRITE SUMMARY REPORT | | PAGE | : 1 | |
|-----------------------|---------------------------|---------------------|----------------------|--|---------|---------|--|--|
| | | | | HECKWRITE DATE: 02/07/2006 | | | | |
| | | | | FINANCIAL PAYER: NCDMH | - | | | |
| | | | | | | | TOTAL | TOTAL |
| PROVIDER NUMBER | | HIGH DENIAL EOBS | NUMBER OF DENIALS | DESCRIPTION | TNC | TOTAL | CLAIMS | CLAIMS |
| - Cranat | PROVIDER NAME | 2023 | DENTARD | DESCRIPTION OF THE PROPERTY OF | DENIALS | DENIALS | FINALIZED | PAID |
| 3404901 | SMOKY MOUNTAINM | 8599 | 2131 | DETAIL NOT COVERED BY COMBINAT | | | | |
| | H/DD/SAS | | | ION OF RECIPIENT, PROVIDER AND BENEFIT PACKAGE. | | | | |
| | | | | | | | | |
| | | 191 | 522 | CLIENT ID NUMBER DOES NOT MATC H PATIENT NAME | 60 | 3102 | 3501 | 39 |
| | | | | M PATIENT NAME | | | | |
| | | | | | | | | |
| | | 143 | 290 | CLIENT ID NUMBER NOT ON STATE ELIGIBILITY FILE | | | | |
| | | | | | | | | |
| 3404904 | | 191 | 46 | CLIENT ID NUMBER DOES NOT MATC | | | | |
| 3404904 | WESTERN HIGHLAN DS LME | 191 | 40 | H PATIENT NAME | | | | |
| | DO LIVE | | | | | | | |
| | | 8533 | 46 | SERVICE FACILITY LOCATION CANN | | 400 | 7504 | 245 |
| | | | | OT BE AN ATTENDING PROVIDER | 0 | 133 | 7584 | 745 |
| | | | | IDENTIFIED AS AN INDIVIDUAL. | | | | |
| | | 8537 | 13 | PROCEDURE IS NOT PAYABLE FOR Y | | - | | |
| | | | | OUR PROVIDER TYPE AND | | | | |
| | | | | SPECIALTY IN ACCORDANCE TO MEN | | | | |
| 3404910 | DAMINA VO | 8505 | 1940 | CLAIM DENIED DUE TO INSUFFICIE | | | | |
| | PATHWAYS | | 1 | NT BUDGET | _ | | | |
| | | | | | | | | |
| | | 8534 | 197 | SERVICE FACILITY LOCATION IS N | 2 | 2858 | 6099 | 324 |
| | | | | OT A VALID IPRS ATTENDING | | 2000 | 0033 | 324 |
| | | | | PROVIDER. PLEASE VERIFY THE F | | | | |
| | | 11 | 183 | CLIENT NOT ELIGIBLE ON SERVICE | | | | |
| | | | | DATE | | | | |
| | | | | | | | | |
| 3404912 | CATAWBA COUNTYM | 21 | 36 | DUPLICATE OF CLAIM-SYSTEM | | | | |
| | ENTAL HEALT | | | | | | | |
| | | | | | | | | |
| | | 11 | 35 | CLIENT NOT ELIGIBLE ON SERVICE | 8 | 108 | 1918 | 181 |
| | | | | DATE | | | | |
| | | | | | | | | |
| | | 8621 | 15 | 60 RESIDENTIAL LEVEL III TREAT | | | | |
| | | | | MENT RECEIVED, PA IS REQUIRED | | | | |
| | | | | FOR ADDITIONAL SERVICE. | | | | |
| 3404913 | MECKLENBURG COM | 8599 | 38 | DETAIL NOT COVERED BY COMBINAT | | | | |
| | ENTAL HEALT | | | ION OF RECIPIENT, PROVIDER AND | | | | |
| | | | | BENEFIT PACKAGE. | | | | |
| | | 11 | 23 | CLIENT NOT ELIGIBLE ON SERVICE | 10 | 71 | 314 | 24 |
| | | | | DATE | | | | |
| | | | 1 | | - | | | |
| | | 8935 | 8 | ASTNC INELIGIBLE TO RECEIVE SE | | | | |
| | + | 1 | + | RVICES IN IPRS. | | | | |
| | | | + | | - | | | |
| 3404916 | CROSSROADS BEHA | 21 | 492 | DUPLICATE OF CLAIM-SYSTEM | | | | |
| | VIORAL HEAL | | - | | | - | | |
| | | | + | | _ | | | |
| | | 8599 | 78 | DETAIL NOT COVERED BY COMBINAT | 0 | 641 | 10642 | 1000 |
| | | | 1 | ION OF RECIPIENT, PROVIDER AND BENEFIT PACKAGE. | - | | | |
| | | | + | | _ | | | |
| | | 120 | 30 | CLIENT ID NUMBER MISSING OR IN | | | | |
| | | | + | VALID. ENTER CID AND SUBMIT AS A NEW CLAIM | | - | | |
| | | | | | | | | |
| 3404917 | CENTERPOINT HUM | 11 | 1549 | CLIENT NOT ELIGIBLE ON SERVICE DATE | | | | |
| | AN SERVICES | | | | - | | | |
| | | | | | | | | |
| | | 8518 | 512 | CLAIM DENIED, SUBMITTED BEYOND FILING TIMELIMIT. PRIOR | 116 | 3195 | 9215 | 602 |
| | 1 | - | - | FISCAL YEAR DOS (JULY 1 - JUNE | _ | | | - |
| | | | | FISCAL TEAR DOS (JULI I - JUNE | | | | |
| | | | | | | | | |
| | | 8599 | 338 | DETAIL NOT COVERED BY COMBINAT ION OF RECIPIENT, PROVIDER AND | | | | |

| | | | | | | | TOTAL | TOTAL |
|----------|--------------------------------|-------------|-----------|--|---------|-----------|-----------|--------|
| PROVIDER | | HIGH DENIAL | NUMBER OF | | TNC | TOTAL | CLAIMS | CLAIMS |
| IUMBER | PROVIDER NAME | EOBS | DENIALS | DESCRIPTION | DENIALS | DENIALS | FINALIZED | PAID |
| 8404918 | ROCKINGHAM CO M | 0 | 0 | *** NO DATA TO REPORT *** | | | | |
| | ENTAL HEALT | | | | | | | |
| | | | | | | | | |
| | | 0 | 0 | | 0 | 0 | 0 | 0 |
| | | | | | | | 0 | |
| | | 0500 | 4.05 | | | | | |
| 8404919 | GUILFORD CO MEN TAL HEALTHC | 8599 | 175 | DETAIL NOT COVERED BY COMBINAT ION OF RECIPIENT, PROVIDER AND | | | | |
| | TAL REALTHC | | | BENEFIT PACKAGE. | | | | |
| | | | | | | | | |
| | | 21 | 80 | DUPLICATE OF CLAIM-SYSTEM | 33 | 393 | 5628 | 5235 |
| | | | | | | | | |
| | | | | | | | | |
| | | 191 | 49 | CLIENT ID NUMBER DOES NOT MATC H PATIENT NAME | | | | |
| | | | | | | | | |
| | | | | | | | | |
| 404920 | ALAMANCE CASWEL | 8599 | 1099 | DETAIL NOT COVERED BY COMBINAT ION OF RECIPIENT, PROVIDER AND | | | | |
| | L AREA MH D | | | BENEFIT PACKAGE. | | | | |
| | | | | | | | | |
| | | 8505 | 611 | CLAIM DENIED DUE TO INSUFFICIE | 41 | 2924 | 11535 | 8611 |
| | | | | NT BUDGET | | | | |
| | | | | | | | | |
| | | 11 | 285 | CLIENT NOT ELIGIBLE ON SERVICE DATE | | | | |
| | | 1 | | ACCEPANCE OF THE PROPERTY OF T | | | | |
| | | | | | | | | |
| 404921 | ORANGE PERSON C | 8505 | 2904 | CLAIM DENIED DUE TO INSUFFICIE | | | | |
| | HATHAM AREA | | | NT BUDGET | | | | |
| | | | | | | | | |
| | | 8599 | 402 | DETAIL NOT COVERED BY COMBINAT | 14 | 4090 | 8176 | 4086 |
| | | | | ION OF RECIPIENT, PROVIDER AND BENEFIT PACKAGE. | | | | |
| | | | | DENEFII FACAGE. | | | | |
| | | 21 | 305 | DUPLICATE OF CLAIM-SYSTEM | | | | |
| | | | | | | | | |
| | | | | | | | | |
| 404922 | THE DURHAM CENT | 8599 | 1277 | DETAIL NOT COVERED BY COMBINAT | | | | |
| | ER | | | ION OF RECIPIENT, PROVIDER AND | | | | |
| | | | | BENEFIT PACKAGE. | | | | |
| | | 21 | 313 | DUPLICATE OF CLAIM-SYSTEM | 90 | 2485 | 21727 | 19242 |
| | | | | | | | | |
| | | | | | | | | |
| | | 191 | 146 | CLIENT ID NUMBER DOES NOT MATC | | | | |
| | | | | H PATIENT NAME | | | | |
| | | | | | | | | |
| 404923 | FIVE COUNTY MH | 8599 | 235 | DETAIL NOT COVERED BY COMBINAT | | | | |
| | | | | ION OF RECIPIENT, PROVIDER AND | | | | |
| | | | | BENEFIT PACKAGE. | | | | |
| | | 8000 | 172 | NO RATE AVAILABLE ON FILE TO P | 2 | 809 | 7153 | 6344 |
| | | | | RICE THIS CLAIM DETAIL | | | | |
| | | | | | | | | |
| | | 11 | 90 | CLIENT NOT ELIGIBLE ON SERVICE | | | | |
| | | | | DATE | | | | |
| | | | | | | | | |
| 404925 | SANDHILLS CENTE | 8599 | 986 | DETAIL NOT COVERED BY COMBINAT | | | | |
| | R FOR MH/DD | | | ION OF RECIPIENT, PROVIDER AND | | | | |
| | | | | BENEFIT PACKAGE. | | | | |
| | | 21 | 799 | DUPLICATE OF CLAIM-SYSTEM | 175 | 3960 | 11158 | 7198 |
| | | | | | | | | |
| | | | | | | | | |
| | | 8505 | 531 | CLAIM DENIED DUE TO INSUFFICIE | | | | |
| | | | | NT BUDGET | | | | |
| | | | | | | | | |
| 104926 | SOUTHEASTERN RE | 5404 | 3500 | SEVERE DUPLICATE: SAME ATTD PR | | | | |
| | G MENTAL HL | | | OV/FCODE/TOS/DOS/MOD | | | | |
| _ | | | | | | _ | | |
| | | 21 | 1190 | DUPLICATE OF CLAIM-SYSTEM | 630 | 7549 | 11456 | 3907 |
| | | | | | 030 | , , , , , | 11436 | 3307 |
| | 1 | | | | | | | |
| | | | | | | | | |
| | | 8599 | 869 | DETAIL NOT COVERED BY COMBINAT | | | | |
| | | 8599 | 869 | DETAIL NOT COVERED BY COMBINAT ION OF RECIPIENT, PROVIDER AND BENEFIT PACKAGE. | | | | |

| nnourre | | HEAT DENIES | www.nnn | | | | TOTAL | TOTAL |
|----------|-------------------------------|------------------------|--|---|---------|---------|-----------|--------|
| PROVIDER | | HIGH DENIAL EOBS | NUMBER OF DENIALS | DESCRIPTION | TNC | TOTAL | CLAIMS | CLAIMS |
| NUMBER | PROVIDER NAME | EUBS | DENIALS | DESCRIPTION | DENIALS | DENIALS | FINALIZED | PAID |
| 3404927 | OWNERSTAND OO M | 8505 | 219 | CLAIM DENIED DUE TO INSUFFICIE | | | | |
| | CUMBERLAND CO M | | | NT BUDGET | | | | |
| | 110 | | | | | | | |
| | | | | | | | | |
| | | 21 | 149 | DUPLICATE OF CLAIM-SYSTEM | 1 | 550 | 3502 | 295 |
| | | | | | | | | |
| | | | | | | | | |
| | | 0500 | 70 | | | | | |
| | | 8599 | 73 | DETAIL NOT COVERED BY COMBINAT ION OF RECIPIENT, PROVIDER AND | | | | |
| | | | | BENEFIT PACKAGE. | | | | |
| | | | | | | | | |
| 3404929 | LEE HARNETT MH/ | 0 | 0 | *** NO DATA TO REPORT *** | | | | |
| | DD/SAS | | | | | | | |
| | | | | | | | | |
| | | | | | | | | |
| | | 0 | 0 | | 0 | 0 | 0 | |
| | | | | | | | | |
| 3404930 | | 8599 | 154 | DETAIL NOT COVERED BY COMBINAT | | | | |
| 3404930 | JOHNSTON COUNTY | 6599 | 154 | ION OF RECIPIENT, PROVIDER AND | | | | |
| | MNTL HLTHC | + | + | BENEFIT PACKAGE. | | | | 1 |
| | | | | | | | | |
| | | 8931 | 41 | AMTNC INELIGIBLE TO RECEIVE SE | 60 | 279 | 3996 | 371 |
| | | | | RVICES IN IPRS. | | -17 | 2330 | |
| | | | | | | | | |
| | | | | | | | | |
| | | 8329 | 22 | CLAIM DENIED ATTENDING PROVIDE R CANNOT BE THE SAME AS | | | | |
| | | | | R CANNOT BE THE SAME AS THE LMA | | | | |
| | | | | A SAME AND A SAME | | | | |
| 3404931 | MAKE CO HIM SIC | 8599 | 410 | DETAIL NOT COVERED BY COMBINAT | | | | |
| | WAKE CO HUM SVC BILLING OF | | | ION OF RECIPIENT, PROVIDER AND | | | | |
| | DIBLING OF | | | BENEFIT PACKAGE. | | | | |
| | | | | | | | | |
| | | 21 | 125 | DUPLICATE OF CLAIM-SYSTEM | 196 | 1015 | 17646 | 1663 |
| | | | | | | | | |
| | | | | | | | | |
| | | | | | | | | |
| | | 8931 | 116 | AMTNC INELIGIBLE TO RECEIVE SE RVICES IN IPRS. | | | | |
| | | | | RVICES IN IPRS. | | | | |
| | | | | | | | | |
| 3404933 | SOUTHEASTERN CT | 8599 | 1966 | DETAIL NOT COVERED BY COMBINAT | | | | |
| | R FOR MH/DD | | | ION OF RECIPIENT, PROVIDER AND | | | | |
| | | | | BENEFIT PACKAGE. | | | | |
| | | | | | | | | |
| | | 8329 | 157 | CLAIM DENIED ATTENDING PROVIDE | 34 | 2363 | 7808 | 544 |
| | | | | R CANNOT BE THE SAME AS | | | | |
| | | | | THE LMA | | | | |
| | | 79 | 63 | MUTA APPARATE TO NOW DAVABLE TO | | | | |
| | | 79 | 63 | THIS SERVICE IS NOT PAYABLE TO YOUR SUBMITTED BILLING | | | | |
| | | | | PROVIDER TYPE AND SPECIALTY IN | | | | |
| | | | | | | | | |
| 3404934 | ONSLOW CARTERET | 11 | 143 | CLIENT NOT ELIGIBLE ON SERVICE | | | | |
| | BEHAV HEAL | | | DATE | | | | |
| | | | | | | | | |
| | | | | | | | | |
| | | 8952 | 3 | CLAIM DENIED DUE TO AGE RESTRI | 0 | 147 | 235 | 8 |
| | | | | | | | | 1 |
| | | | | CTIONS FOR TARGET POPULATION | | | | |
| | | | | CTIONS FOR TARGET POPULATION | | | | |
| | | 8599 | 1 | | | | | |
| | | 8599 | 1 | CTIONS FOR TARGET POPULATION DETAIL NOT COVERED BY COMBINAT ION OF RECIPIENT, PROVIDER AND | | | | |
| | | 8599 | 1 | DETAIL NOT COVERED BY COMBINAT | | | | |
| | | 8599 | 1 | DETAIL NOT COVERED BY COMBINAT ION OF RECIPIENT, PROVIDER AND | | | | |
| 3404935 | WAYNE CO MENTAL | 8599 | 1 | DETAIL NOT COVERED BY COMBINAT ION OF RECIPIENT, PROVIDER AND | | | | |
| 3404935 | WAYNE CO MENTAL HEALTH CTR | 8599 | 1 | DETAIL MOT COVERED BY COMBINAT ION OF RECIFIENT, PROVIDER AND BENEFIT FACKAGE. | | | | |
| 3404935 | | 8599 | 0 | DETAIL MOT COVERED BY COMBINAT ION OF RECIFIENT, PROVIDER AND BENEFIT FACKAGE. | | | | |
| 3404935 | | 8599 | 0 | DETAIL MOT COVERED BY COMBINAT ION OF RECIFIENT, PROVIDER AND BENEFIT FACKAGE. | | | | |
| 3404935 | | 0 | 0 | DETAIL MOT COVERED BY COMBINAT ION OF RECIFIENT, PROVIDER AND BENEFIT FACKAGE. | 0 | 0 | 0 | |
| 3404935 | | 8599 | 0 | DETAIL MOT COVERED BY COMBINAT ION OF RECIFIENT, PROVIDER AND BENEFIT FACKAGE. | 0 | 0 | 0 | |
| | HEALTH CTR | 0 | 0 | DETAIL NOT COVERED BY COMBINAT ION OF RECIPIENT, PROVIDER AND BENEFIT FACKAGE. *** NO DATA TO REPORT *** | 0 | 0 | 0 | |
| | HEALTH CTR WILSON-GREENE M | 0 0 8599 | 0 0 | DETAIL NOT COVERED BY COMBINAT ION OF RECIFIENT, PROVIDER AND SENEFIT FACKAGE. *** NO DATA TO REPORT *** DETAIL NOT COVERED BY COMBINAT | 0 | 0 | 0 | |
| | HEALTH CTR | 0 | 0 | DETAIL NOT COVERED BY COMBINAT ION OF RECIPIENT, PROVIDER AND BENEFIT FACKAGE. *** NO DATA TO REPORT *** | 0 | 0 | 0 | |
| | HEALTH CTR WILSON-GREENE M | 0 | 0 0 165 | DETAIL NOT COVERED BY COMBINAT ION OF RECIPIENT, PROVIDER AND BENEFIT FACKAGE. *** NO DATA TO REPORT *** DETAIL NOT COVERED BY COMBINAT ION OF RECIPIENT, PROVIDER AND | 0 | 0 | 0 | |
| | HEALTH CTR WILSON-GREENE M | 0 | 0 0 165 | DETAIL NOT COVERED BY COMBINAT ION OF RECIPIENT, PROVIDER AND BENEFIT FACKAGE. *** NO DATA TO REFORT *** DETAIL NOT COVERED BY COMBINAT ION OF RECIPIENT, PROVIDER AND BENEFIT FACKAGE. AMTNC INELIGIBLE TO RECEIVE SE | 0 | 0 | 0 | |
| | HEALTH CTR WILSON-GREENE M | 0 0 8599 | 0 0 165 | DETAIL NOT COVERED BY COMBINAT ION OF RECIFIENT, PROVIDER AND BENEFIT FACKAGE. *** NO DATA TO REPORT *** DETAIL NOT COVERED BY COMBINAT ION OF RECIFIENT, PROVIDER AND BENEFIT PACKAGE. | 0 | | | |
| | HEALTH CTR WILSON-GREENE M | 0 0 8599 | 0 0 165 | DETAIL NOT COVERED BY COMBINAT ION OF RECIPIENT, PROVIDER AND BENEFIT FACKAGE. *** NO DATA TO REFORT *** DETAIL NOT COVERED BY COMBINAT ION OF RECIPIENT, PROVIDER AND BENEFIT FACKAGE. AMTNC INELIGIBLE TO RECEIVE SE | 0 | | | |
| 3404935 | HEALTH CTR WILSON-GREENE M | 0 0 8599 8931 | 0 0 165 | DETAIL NOT COVERED BY COMBINAT ION OF RECIPIENT, PROVIDER AND SENEFIT PACKAGE. *** NO DATA TO REPORT *** DETAIL NOT COVERED BY COMBINAT ION OF RECIPIENT, PROVIDER AND BENEFIT PACKAGE. AMTNC INELIGIBLE TO RECEIVE SE RVICES IN IPRS. | 0 | | | |
| | HEALTH CTR WILSON-GREENE M | 0 0 8599 | 0 0 165 | DETAIL NOT COVERED BY COMBINAT ION OF RECIFIENT, PROVIDER AND BENEFIT FACKAGE. *** NO DATA TO REPORT *** DETAIL NOT COVERED BY COMBINAT ION OF RECIPIENT, PROVIDER AND BENEFIT FACKAGE. AMTNC INELIGIBLE TO RECEIVE SE RVICES IN IPRS. CLAIM DENIED, SUBMITTED BEYOND | 0 | | | |
| | HEALTH CTR WILSON-GREENE M | 0 0 8599 8931 | 0 0 165 | DETAIL NOT COVERED BY COMBINAT ION OF RECIPIENT, PROVIDER AND SENEFIT PACKAGE. *** NO DATA TO REPORT *** DETAIL NOT COVERED BY COMBINAT ION OF RECIPIENT, PROVIDER AND BENEFIT PACKAGE. AMTNC INELIGIBLE TO RECEIVE SE RVICES IN IPRS. | 0 | | | |

| | | | | | | | TOTAL | TOTAL |
|---------|--------------------------------|-------------|-----------|--|---------|---------|-----------|--------|
| ROVIDER | | HIGH DENIAL | NUMBER OF | | TNC | TOTAL | CLAIMS | CLAIMS |
| UMBER | PROVIDER NAME | EOBS | DENIALS | DESCRIPTION | DENIALS | DENIALS | FINALIZED | PAID |
| 404937 | EDGECOMBE NASH | 8518 | 777 | CLAIM DENIED, SUBMITTED BEYOND | | | | |
| | MNTL HLTH C | | | FILING TIMELIMIT. PRIOR | | | | |
| | | | | FISCAL YEAR DOS (JULY 1 - JUNE | | | | |
| | | | | | | | | |
| | | 21 | 77 | DUPLICATE OF CLAIM-SYSTEM | 3 | 910 | 5656 | 4746 |
| | | | | | | | | |
| | | | | | | | | |
| | | 8599 | 19 | DETAIL NOT COVERED BY COMBINAT | | | | |
| | | | | ION OF RECIPIENT, PROVIDER AND | | | | |
| | | | | BENEFIT PACKAGE. | | | | 2128 |
| | | | | | | | | |
| 404938 | VGFW DBA RIVERS | 0 | 0 | *** NO DATA TO REPORT *** | | | | 401 |
| | TONE COUNSE | | | | | | | |
| | | | | | | | | |
| | | 0 | 0 | | 0 | 0 | 0 | 0 |
| | | | | | | | | |
| | | | 400 | | | | | |
| 404939 | NEUSE MENTAL HE | 21 | 183 | DUPLICATE OF CLAIM-SYSTEM | | | | 2128 |
| | ALTH CENTER | | | | | | | |
| | | | | | | | | |
| | | 8599 | 21 | DETAIL NOT COVERED BY COMBINAT | 0 | 230 | 2358 | 2128 |
| | | | | ION OF RECIPIENT, PROVIDER AND | | | | |
| | | | | BENEFIT PACKAGE. | | | | |
| | | 8622 | 11 | 60 RESIDENTIAL LEVEL II TREATM | | | | |
| | | | | ENT RECEIVED, PA IS REQUIRED | | | | |
| | | | | FOR ADDITIONAL SERVICE. | | | | |
| | | | | | | | | |
| 404941 | PITT CO MH/DD/S | 8599 | 119 | DETAIL NOT COVERED BY COMBINAT | | | | 2128 |
| | AS CENTER | | | ION OF RECIPIENT, PROVIDER AND | | | | |
| | | | | BENEFIT PACKAGE. | | | | |
| | | 27 | 117 | DIAGNOSIS CODE MISSING OR INVA | 2 | 249 | 650 | 401 |
| | | | | LID. VERIFY AND ENTER THE | | 249 | 650 | 401 |
| | | | | CORRECT DIAGNOSIS CODE AND SUB | | | | |
| | | | | | | | | |
| | | 191 | 9 | CLIENT ID NUMBER DOES NOT MATC | | | | |
| | | | | H PATIENT NAME | | | | |
| | | | | | | | | |
| 404942 | BORNOVE CHOMBNIA | 11 | 93 | CLIENT NOT ELIGIBLE ON SERVICE | | | | |
| | ROANOKE CHOWANH UMAN SERVIC | | | DATE | | | | |
| | | | | | | | | |
| | | | | | | | | |
| | | 21 | 60 | DUPLICATE OF CLAIM-SYSTEM | 31 | 219 | 2451 | 2232 |
| | | | | | | | | |
| | | | | | | | | |
| | | 8931 | 30 | AMTNC INELIGIBLE TO RECEIVE SE | | | | |
| | | | | RVICES IN IPRS. | | | | |
| | | | | | | | | |
| | | | | | | | | |
| 404943 | ALBEMARLE MENTA | 79 | 171 | THIS SERVICE IS NOT PAYABLE TO YOUR SUBMITTED BILLING | | | | |
| | L HEALTH CE | | | PROVIDER TYPE AND SPECIALTY IN | | | | |
| | | | | | | | | |
| | | 8599 | 83 | DETAIL NOT COVERED BY COMBINAT | 65 | 417 | 4218 | 3801 |
| | | | | ION OF RECIPIENT, PROVIDER AND | | | | |
| | | | | BENEFIT PACKAGE. | | | | |
| | | 21 | 70 | DUDITORE OF CLAIM OVORTON | | | | |
| | | £ ± | 70 | DUPLICATE OF CLAIM-SYSTEM | | | | |
| | | 1 | | | | | | |
| | | | | | | | | |
| 04944 | EASTPOINTE HUMA | 21 | 13983 | DUPLICATE OF CLAIM-SYSTEM | | | | |
| | N SERVICES | | | | | | | |
| | | | | | | | | |
| | - | 8599 | 802 | DETAIL NOT COVERED BY COMBINAT | | | | |
| | 1 | | 002 | DETAIL NOT COVERED BY COMBINAT ION OF RECIPIENT, PROVIDER AND | 101 | 16048 | 22501 | 6453 |
| | | 1 | | BENEFIT PACKAGE. | | | | |
| | | 1 | | | | | | |
| | | 79 | 348 | THIS SERVICE IS NOT PAYABLE TO | | | | |
| | | | | YOUR SUBMITTED BILLING | | | | |
| | | | | PROVIDER TYPE AND SPECIALTY IN | | | | |
| 104946 | 1 | 21 | 17395 | DUPLICATE OF CLAIM-SYSTEM | | | | |
| .04540 | FOOTHILLS AREAM | | 2.353 | DOLLIGHTE OF CHAIN-SISIEM | | | | |
| | ENTAL HEALT | 1 | | | | | | |
| | | | | | | | | |
| | | 8599 | 377 | DETAIL NOT COVERED BY COMBINAT | 0 | 18416 | 26592 | 8176 |
| | | | | ION OF RECIPIENT, PROVIDER AND | | | | |
| | | | | BENEFIT PACKAGE. | | | | |
| | | 191 | 256 | CITEMS IN NUMBER DOES NOW MAKES | | | | |
| | | 131 | 256 | CLIENT ID NUMBER DOES NOT MATC H PATIENT NAME | | | | |
| | | 1 | I . | | | | | |
| | | | | | | | | |

| | | | | | | | TOTAL | TOTAL |
|----------|--------------------------------|-------------|-----------|--|---------|---------|-----------|--------|
| PROVIDER | | HIGH DENIAL | NUMBER OF | | TNC | TOTAL | CLAIMS | CLAIMS |
| NUMBER | PROVIDER NAME | EOBS | DENIALS | DESCRIPTION | DENIALS | DENIALS | FINALIZED | PAID |
| 3404957 | TIDELAND MENTAL | 8518 | 145 | CLAIM DENIED, SUBMITTED BEYOND | | | | |
| | HEALTH CTR | | | FILING TIMELIMIT. PRIOR | | | | |
| | | | | FISCAL YEAR DOS (JULY 1 - JUNE | | | | |
| | | 8599 | 103 | DETAIL NOT COVERED BY COMBINAT | | 0.00 | 0.400 | 3127 |
| | | | | ION OF RECIPIENT, PROVIDER AND | 39 | 368 | 3495 | 3127 |
| | | | | BENEFIT PACKAGE. | | | | |
| | | 191 | 40 | CLIENT ID NUMBER DOES NOT MATC | | | | |
| | | 191 | 40 | H PATIENT NAME | | | | |
| | | | | | | | | |
| 3404979 | | 167 | 1451 | NO CHARGE BILLED. ENTER BILLED | | | | |
| 3404979 | NEW RIVER AREAM H/DD/SA PRO | 107 | 1431 | AMOUNT AND SUBMIT DETAIL AS | | | | |
| | n/DD/SA PRO | | | A NEW CLAIM | | | | |
| | | | | | | | | |
| | | 21 | 116 | DUPLICATE OF CLAIM-SYSTEM | 31 | 1751 | 5224 | 3473 |
| | | | | | | | | |
| | | | | | | | | |
| | | 8599 | 80 | DETAIL NOT COVERED BY COMBINAT | | | | |
| | | | | ION OF RECIPIENT, PROVIDER AND BENEFIT PACKAGE. | | | - | |
| 1 | | | | DENEFII FACAGE. | | | | |